MDR Tracking Number: M5-04-0852-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 11-20-03.

The IRO reviewed myofascial release, office visits, ultrasound, physical medicine treatment (hot/cold packs and electrical stimulation), group therapeutic procedures, special reports, and physical performance test (muscle testing), electrodes, and analysis/comp data from 12-31-02 through 3-13-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The dispute also contained services not addressed by the IRO and will be reviewed by the Medical Review Division. On 1-28-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
1-14-03 2-14-03	99213 99213	$60.00 $60.00	$0.00	No EOB	$48.00	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of $48.00 x 2 days = $96.00.

1-16-03	J1030 J3490 A4209	$11.27 $30.00 $50.00	$0.00	G	DOP		Drugs and supplies are not global to the surgical procedure. Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.
	20605	$65.00	$51.00	NA	$51.00	NA	Per the EOB, this charge was paid by check #05024745 on 2-25-03. Therefore, no dispute exists.
2-28-03	99213	$60.00	$48.00	NA	$48.00	NA	Per the EOB, this charge was paid by check #05075791 on 3-28-03. Therefore, no dispute exists.
TOTAL		$336.27	$99.00				The requestor is entitled to reimbursement of $96.00

This Decision is hereby issued this 28th day of April 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 12-31-02 through 3-13-03 in this dispute.

This Order is hereby issued this 28th day of April 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DETERMINATION
REVISED 4/27/04

IRO Certificate# 5259
MDR Tracking Number: M5-04-0852-01

January 20, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
Patient diagnosed with bilateral carpal syndrome with a date of injury listed as ___. Treatment consisted of injections, physical medicine modalities and surgery.

REQUESTED SERVICE (S)
Myofascial release, office visits, ultrasound therapy, physical medicine treatment, special reports, electrodes, analysis/comp data and physical performance test from 12/31/02 to 3/13/03.

DECISION
Approved.

RATIONALE/BASIS FOR DECISION
The physician's examination and treatment records adequately document the medical necessity for all treatments and procedures performed from 12/31/02 to 3/13/03. This position is consistent with the opinion of ___ (the carrier's examining doctor), who after reviewing the reports and therapy notes from the Neuromuscular Institute of Texas opined, "Based on the present evaluation, the length and frequency of treatment has been appropriate and necessary."